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No. 96-1375

In the Supreme Court of the United States

OCTOBER TERM, 1996

ST. PAUL-RAMSEY MEDICAL CENTER, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

*ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT*

BRIEF FOR THE RESPONDENT

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60 pp

QUESTION PRESENTED

Under a 1986 amendment to the Medicare Act, 42 U.S.C. 1395ww(h), Congress enacted a new methodology for reimbursing graduate medical education (GME) costs incurred by hospitals that participate in the Medicare program. The amendment directed the Secretary of Health and Human Services (HHS) to "determine," for each hospital's cost reporting year that began during fiscal year 1984 (the base year), the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). The amendment further directed the Secretary to use that base-period per-resident amount, adjusted for inflation, to calculate the hospital's GME reimbursement for reporting periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h)(2); see 42 C.F.R. 413.86. The question presented is:

Whether the Secretary reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's GME costs incurred in the base year for the purpose of determining the reimbursement due in subsequent years.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-3a) is reported at 91 F.3d 57. The opinion of the district court (Pet. App. 4a-8a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 26, 1996. A petition for rehearing was denied on September 30, 1996. Pet. App. 9a. On December 5, 1996, and January 9, 1997, Justice Thomas extended the time within which to file a petition for a writ of certiorari to and including February 27, 1997, and the petition was filed on that date. This Court granted the petition on June 2, 1997. 117 S. Ct. 2406. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services.[1] When eligible patients receive those services, the Secretary reimburses the providers of the services under the Medicare Act and the Secretary's implementing regulations. Under the regulations, the costs of certain educational programs for health professional trainees, including programs for residents known as graduate medical education (GME) programs, are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a); see *Thomas Jefferson University* v. *Shalala*, 512 U.S. 504, 507 (1994).

A provider's total allowable Medicare payment is based on a "cost report[]" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b); see 42 U.S.C. 1395*oo*(a). The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. 42 U.S.C. 1395h. The report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services

[1] Part B is a voluntary supplementary insurance program covering physician and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

during the reporting period. 42 C.F.R. 405.1803; see generally *Bethesda Hospital Ass'n* v. *Bowen*, 485 U.S. 399, 400-401 (1988). A provider dissatisfied with the NPR may request a hearing before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. 1395*oo*(a) and (b); 42 C.F.R. 405.1835, 405.1837. The PRRB's decision is "final," unless, within 60 days, the Secretary reverses, affirms, or modifies it. 42 U.S.C. 1395*oo*(f)(1).[2]

The Act itself does not place any limitations on the time in which a reimbursement decision at any stage of the administrative review process may be reopened to correct an error affecting the amount of reimbursement for a given cost year. By regulation, however, a determination by the intermediary or a decision of the PRRB or the Secretary that is inconsistent with applicable law, regulations, or general instructions issued by the Secretary may be reopened within three years (or at any time if there has been fraud) with respect to findings at issue in the determination. 42 C.F.R. 405.1807(b), 405.1885(a), (b) and (d).

[2] Providers may obtain judicial review of any "final decision" of the PRRB (or of the Secretary, if the Secretary exercises the right of review). 42 U.S.C. 1395*oo*(f)(1). They may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. *Ibid.* The Board is authorized by regulation, 42 C.F.R. 405.1842(g)(2), to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide.

2. From 1966 through 1982, providers of services under Part A were reimbursed for Medicare-covered patient care to the extent the costs were reasonable. 42 U.S.C. 1395f(b)(1) (1982). The reasonable-cost calculation generally was based on the "cost[s] actually incurred," as long as the services were necessary. 42 U.S.C. 1395x(v)(1)(A). The Act authorized the Secretary to issue regulations defining the payment due under that statutory standard. *Ibid*; see *Shalala* v. *Guernsey Memorial Hospital*, 514 U.S. 87, 91-92 (1995). In 1983, Congress introduced a prospective payment system (PPS), which establishes fixed payment rates, based on patient diagnosis, for the operating costs of providing inpatient hospital care to program beneficiaries. See 42 U.S.C. 1395ww(d); *Good Samaritan Hospital* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993). The PPS methodology was implemented over a four-year period, during which a progressively declining portion of the reimbursement was based on a hospital-specific rate derived from the hospital's actual costs in a given base year, and a gradually increasing portion was based on a federal rate reflecting regional and national standardized amounts. See 42 U.S.C. 1395ww(d)(1)(C). Costs incurred in connection with GME programs were excluded from the PPS scheme. 42 U.S.C. 1395ww(a)(4) and (d)(1)(A); *Thomas Jefferson University*, 512 U.S. at 509. Until July 1985, GME costs continued to be reimbursed on a "reasonable cost" basis.

In the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, enacted on April 7, 1986, Congress changed the method for calculating reimbursable GME costs by providing that, subject to updating for inflation, the calculation of GME costs to

be reimbursed in all subsequent years would be based on the amount of allowable GME costs incurred by the provider for a fiscal year that began between October 1, 1983, and September 30, 1984 (the base year). See Medicare and Medicaid Budget Reconciliation Amendments of 1985 (MMBRA), Pub. L. No. 99-272, Tit. IX, § 9202(a), 100 Stat. 171-175, 42 U.S.C. 1395ww(h) (the GME Amendment); see also 42 C.F.R. 413.86(e)(1)(i)(A); *Thomas Jefferson University*, 512 U.S. at 510. As the initial step in the reimbursement process, the GME Amendment provides that "[t]he Secretary shall determine [for the base year] the average amount recognized as reasonable under [the Act] for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. 1395ww(h)(2)(A). Specifically, the Secretary was directed to calculate a per-resident amount for each hospital by dividing the amount of GME costs "recognized as reasonable" for the base period of 1984 (numerator) by the number of full-time-equivalent residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement for any given year, the approved GME per-resident amount, adjusted for inflation, is then multiplied by the weighted number of full-time-equivalent residents in the hospital, as determined under 42 U.S.C. 1395ww(h)(4), and the hospital's Medicare patient load that year. 42 U.S.C. 1395ww(h)(3). Congress instructed the Secretary to apply the new methodology retroactively "to hospital cost reporting periods beginning on or after July 1, 1985." MMBRA § 9202(b), 100 Stat. 175, 42 U.S.C. 1395ww note.

On September 21, 1988, the Secretary published and invited comment on a proposed regulation implementing the GME Amendment. 53 Fed. Reg. 36,589.

Although the Secretary already had reimbursed most hospitals for their fiscal-year 1984 GME costs, the proposed regulation authorized fiscal intermediaries to reexamine providers' costs from the base year and to conduct a reaudit if the claimed base-year costs appeared to include "misclassified or nonallowable costs," or were "unreasonably high." *Id.* at 36,592. The Secretary explained that the agency had reason to believe some "questionable" GME costs had been "erroneously reimbursed" to providers for the base year. *Id.* at 36,591. Because the Secretary concluded that those past mistakes should not be "perpetuated" under the new GME cost-reimbursement methodology, the reauditing authority was needed to ensure an "accurate" determination of providers' base-year GME costs. *Id.* at 36,591-36,592. The Secretary believed that "the provisions of [Section 1395ww(h)] would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the final regulation, issued on September 29, 1989 (54 Fed. Reg. 40,286-40,301, 40,316; 42 C.F.R. 413.86), the Secretary reiterated that it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301.[3] The Secretary assured providers

[3] The Secretary pointed out that the base year for GME costs was also the first year for the new prospective payment system, and expressed the "belie[f] that GME costs were not given sufficient scrutiny at the time because of the many changes that were taking place in Medicare generally." 54 Fed. Reg. 40,301. The Secretary also was concerned that fiscal intermediaries had not been consistent in their treatment of GME costs. *Id.* at 40,302.

that, in reauditing 1984 GME costs, "no new reimbursement principles will be applied * * * [;] [r]ather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." *Ibid.* In response to a comment that the three-year reopening limitation in 42 C.F.R. 405.1885 should not be waived for the reauditing activity, the Secretary stressed that the reaudits would not be used to recoup erroneous reimbursement for cost reports that had been settled for more than three years under the reopening regulation. 54 Fed. Reg. 40,302. Rather, they would be used to recalculate base-year costs "solely for purposes of computing the per resident amount" under the new method for reimbursing GME costs for 1985 and "subsequent years still subject to reopening." *Id.* at 40,301, 40,302.

As finally written, the reaudit regulation directs fiscal intermediaries to determine for every Medicare hospital a "base-period per resident amount." 42 C.F.R. 413.86(e)(1)(i). In making that determination, the intermediary "[v]erifies" each hospital's base-period GME costs and its average number of full-time-equivalent residents; "[e]xcludes" from those base-period GME costs "any nonallowable or misclassified costs, including those previously allowed under * * * this chapter"; and, upon the hospital's request, includes GME costs that were misclassified as operating costs during the base period. 42 C.F.R. 413.86(e)(1)(ii)(A)-(C).[4] If a cost report for the GME base

[4] The regulation also provides that, if the reaudit results in a disallowance based on costs that should have been classified as operating rather than educational costs, a hospital may request an upward adjustment to its hospital-specific rate during the four-year PPS transition period to reflect those higher operat-

period is no longer subject to reopening under Section 405.1885, however, the regulation provides that "the intermediary may modify the hospital's base-period GME costs solely for purposes of computing the per resident amount." 42 C.F.R. 413.86(e)(1)(iii). The regulation also authorizes a hospital to appeal to the PRRB the intermediary's determination of the base-period per-resident amount within 180 days of the date of the intermediary's notice of its determination. 42 C.F.R. 413.86(e)(1)(v).

3. Petitioner, St. Paul-Ramsey Medical Center, Inc., is a teaching hospital that provides Medicare services. J.A. 11 (Compl. ¶ 10). On February 28, 1986, petitioner received an NPR from its fiscal intermediary for its cost-reporting year ending December 31, 1984. J.A. 17 (Compl. ¶ 35). The NPR reflected total GME costs of $9,892,644. Pet. App. 2a.[5]

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ing costs. 42 C.F.R. 413.86(e)(1)(iv) and (j)(1)(i). Conversely, the regulation provides that, in order to increase the GME "base-period per resident amount," a hospital may request that the intermediary include GME costs that previously were misclassified as operating costs, as long as the hospital likewise requests an adjustment of its hospital-specific rate to reflect the reclassification. 42 C.F.R. 413.86(e)(1)(ii)(C) and (j)(2)(i). For purposes of obtaining reimbursement, both adjustments were made effective for cost-reporting periods that were still subject to reopening under the three-year period set forth in Section 405.1885. See 54 Fed. Reg. 40,300-40,302 (1989); 42 C.F.R. 413.86(j)(1)(i) and (iii), and (2)(i) and (iii). The Secretary explained that, in both situations in which hospital-specific rates could be adjusted at the hospital's request, "the recomputation works to the benefit of the hospitals involved." 54 Fed. Reg. 40,301 (1989).

[5] Petitioner apparently did not appeal that NPR to the PRRB. Accordingly, as of March 1, 1989, three years and one day after the NPR was issued, the intermediary's determination was no longer subject to reopening for purposes of altering

In late 1990, fiscal intermediaries began to implement the new methodology for reimbursing GME costs under the GME Amendment by reviewing and, where appropriate, reauditing the base-year cost reports of a number of teaching hospitals that provide Medicare services, including petitioner. On February 18, 1991, petitioner's fiscal intermediary notified petitioner that, upon redetermination, its base-period per-resident amount was $46,254, which was computed by dividing total allowable GME costs for the base period of $5,494,955 by 118.8 full-time-equivalent residents. Admin. Rec. 124-125. Thus, the redetermined amount of petitioner's allowable GME costs for the base year was $4,397,689 less than the $9,892,644 in GME costs that the intermediary had approved in petitioner's NPR. Pet. App. 2a. Although it was evident that petitioner had received excessive reimbursement for 1984 GME costs, no recoupment action was taken against it by the intermediary or the Secretary because the total amount of reimbursement based on petitioner's 1984 cost report had been finally determined. Instead, the intermediary notified petitioner that it would use the reaudited GME cost amount solely to determine petitioner's reimbursable GME amount for all cost-reporting years beginning on or after July 1, 1985, for which the three-year reopening period had not already elapsed. Pet. 7-8; see 42 C.F.R. 413.86(e)(1)(iii).

On August 13, 1991, petitioner appealed the intermediary's notice of the base-period per-resident amount to the PRRB. Pet. 8; Admin. Rec. 119. Petitioner challenged 169 adjustments that were made by the intermediary in the reaudit. Admin. Rec. 108-114,

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the total amount of reimbursement to petitioner for that year. 42 C.F.R. 405.1807, 405.1885(a).

119-120. On February 28, 1994, petitioner withdrew all of its challenges to the intermediary's reaudit, except a challenge to the statistical methodology used by the intermediary to allocate physician teaching costs to medical school students. *Id.* at 20-21 & n.1. Petitioner also challenged the facial validity of the GME regulation authorizing the reaudit, arguing that the GME Amendment required the Secretary to determine petitioner's base-period per-resident amount by using the amount that was reflected in petitioner's NPR for the base period, reimbursed by the Secretary, and no longer subject to administrative reopening. *Id.* at 20. On September 16, 1994, petitioner notified the PRRB that the statistical issue had been settled in principle. *Id.* at 3-4.[6] On September 28, 1994, the PRRB concluded that it lacked authority to invalidate the GME regulation, thereby allowing petitioner to seek expedited judicial review under 42 U.S.C. 1395*oo*(f)(1). Admin. Rec. 1-2; see note 2, *supra*.

4. Petitioner filed suit in the United States District Court for the District of Minnesota challenging the validity of the GME reaudit regulation. On the parties' cross-motions for summary judgment, the district court upheld the regulation. Pet. App. 4a-8a.

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[6] On September 21, 1994, the parties entered into a formal settlement agreement under which the intermediary agreed to reconsider petitioner's physician teaching costs for medical students. On January 13, 1995, the intermediary notified petitioner that it had revised petitioner's base-period per-resident amount from $46,254 to $49,805.29, calculated by dividing GME base-year costs of $5,916,868 by 118.8 full-time-equivalent residents. See Letter from Leonard Thies, Audit Manager, Blue Cross and Blue Shield of Minnesota, to John Bloom, Reimbursement Manager, St. Paul-Ramsey Medical Center (Jan. 13, 1995).

The court observed (*id.* at 7a) that petitioner's arguments supporting its challenge to the reaudit regulation had been considered and rejected by the United States Court of Appeals for the District of Columbia Circuit in *Administrators of the Tulane Educational Fund* v. *Shalala*, 987 F.2d 790 (1993), cert. denied, 510 U.S. 1064 (1994), and by the District Court for the Northern District of Ohio in *Toledo Hospital* v. *Secretary of Health & Human Services*, No. 3:94CV7080 (June 23, 1995), rev'd, 104 F.3d 791 (6th Cir. 1997), petition for cert. pending, No. 96-2046 (filed June 25, 1997).[7] The court found those decisions "persuasive, thorough, well-reasoned and indistinguishable from the present case." Pet. App. 8a. Accordingly, the court "adopt[ed]" the analyses of those decisions and granted summary judgment in favor of the Secretary. *Ibid.*

5. The court of appeals affirmed. Pet. App. 1a-3a. The court explained that "the Secretary's reaudit regulations must be upheld for the reasons persuasively stated by the D.C. Circuit in *Tulane*." *Id.* at 3a. Thus, the court concluded that "[t]he statute is ambiguous, and the reaudit regulations are not an exercise in retroactive rulemaking." *Ibid.* The court observed that, "[w]hile it would have been far preferable had the Secretary promulgated the reaudit regulations during the three-year reopening period governing 1984 reimbursements, the substance of the regulations is clearly reasonable." *Ibid.*

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[7] The opinions of the Sixth Circuit in *Toledo* and of the D.C. Circuit in *Tulane* are reproduced in the certiorari petition in this case at Pet. App. 20a-37a and 38a-54a, respectively. Hereafter, references to the opinions in those cases are to the Pet. App.

SUMMARY OF ARGUMENT

I. The familiar two-step analysis of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), requires that, if Congress has not "directly spoken to the precise question at issue," courts must sustain an agency's interpretation of an Act of Congress so long as it is "based on a permissible construction of the statute." Moreover, where, as here, the Act confers legislative rulemaking authority on the Secretary, the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." See *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990) (quoting *Chevron*, 467 U.S. at 843-844). Here, Congress has not spoken to the precise question at issue, and the Secretary's interpretation of 42 U.S.C. 1395ww(h)(2)(A), as reflected in the reaudit rule, is plainly reasonable. *A fortiori*, it is not "arbitrary, capricious, or manifestly contrary to the Act."

A. The text of Section 1395ww(h)(2)(A) is ambiguous. The Medicare Act provides that the Secretary "shall determine" for a hospital's base year of 1984 "the average amount recognized as reasonable under this subchapter" for GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). That language—which does not specify any methodology for determining a hospital's reasonable base-year GME costs—is subject to varying interpretations. Thus, the phrase "recognized as reasonable under this subchapter" could refer to an amount of base-year GME costs that *is* recognized as reasonable under the substantive standards of reasonableness in the Medicare Act and implementing regulations as applied by the Secretary through the reauditing process. Alternatively, it could refer to an amount of

base-year GME costs that *was* recognized as reasonable in connection with the intermediary's prior issuance of an NPR based on the provider's cost report.

Under the Act, the Secretary has wide authority to issue regulations to define reasonable costs. 42 U.S.C. 1395x(v)(1)(A), 1395hh. In light of that long-standing authority, the Secretary reasonably construed the GME Amendment to permit a reexamination of base-year GME costs to ensure that they are "recognized as reasonable" under the reasonable-cost principles of the Act and implementing regulations in effect during the base year. Petitioner's contrary contention—that the GME Amendment clearly prohibits such reexamination and thus requires perpetuation of errors from settled cost years into all future cost years—lacks merit.

B. The reaudit rule is based on a permissible interpretation of the Act and is not arbitrary or capricious. It furthers Congress's intent in the GME Amendment to limit future Medicare reimbursements for GME costs. The original reviews of base-year GME costs, which were conducted at the time major changes were taking place in the Medicare program, included substantial overpayments resulting from misclassified and nonallowable costs. Thus, the reaudit rule reflects the Secretary's entirely sensible view that Congress would not have wanted to cement prior errors into all future GME payments simply because reimbursements in certain prior years based on those errors cannot be corrected.

The reaudit rule is consistent with principles of fairness and repose. The Secretary's regulation does not upset settled expectations with respect to past reimbursements, but instead permits a reexamination of base-year GME costs solely for purposes of de-

termining subsequent reimbursement for cost years still subject to administrative review or reopening. Further, the rule is not invalid on its face because of the possibility that hospitals (albeit apparently not petitioner) may have discarded certain records relating to base-year GME costs prior to the time of the reaudit. The proposed rule issued in 1988 and the final rule issued in 1989 put providers on notice that their GME costs might be reaudited. In any event, the Secretary reasonably responded to the concern about records by providing alternative means by which providers could prove their entitlement to Medicare reimbursement. In addition, the reaudit rule reasonably accorded hospitals the opportunity to request an upward adjustment of their hospital-specific rates during the PPS transition period in the event the reaudit revealed that base-year GME costs should have been classified as operating costs.

II. The reaudit rule is not impermissibly retroactive under this Court's decisions in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988), and *Landgraf* v. *USI Film Products*, 511 U.S. 244 (1994). The reaudit rule does not permit the Secretary to reopen administratively settled cost reports in order to recoup GME overpayments to providers during those closed periods. Nor is the Secretary's rule rendered retroactive simply because "it draws upon antecedent facts for its operation." *Landgraf*, 511 U.S. at 270 n.24. Moreover, because the rule does not reopen settled cost years for purposes of recouping reimbursement, the rule does not impermissibly increase a hospital's liability or create a new cause of action for past conduct. Finally, the reaudits apply only those reasonable-cost principles that were in effect during

the base year. Thus, the reaudit rule does not apply new legal standards to prior conduct.

ARGUMENT

I. THE GME REAUDIT REGULATION REFLECTS A PERMISSIBLE CONSTRUCTION OF THE GME AMENDMENT

The GME Amendment to the Medicare Act directs the Secretary to "determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. 1395ww(h)(2)(A). The issue in this case is whether the Secretary reasonably construed that provision to permit a reexamination of the reasonable costs of GME training programs in the 1984 base year for the purpose of computing the amounts due in subsequent years.

It is axiomatic that, if a court determines that a congressional enactment speaks directly "to the precise question at issue," the court "must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). If "the statute is silent or ambiguous with respect to the specific issue," however, the court must sustain an agency's interpretation and implementing regulations if they are "based on a permissible construction of the statute." *Id.* at 843. In this case, moreover, Congress has conferred legislative rulemaking authority on the Secretary in the implementation of the Medicare Act. See 42 U.S.C. 405(a) (as incorporated in the Medicare program by 42 U.S.C. 1395ii), 1395x(v)(1)(A), 1395hh; *Good Samaritan Hospital* v.

Shalala, 508 U.S. 402, 418-419 & n.13 (1993); *Sullivan* v. *Zebley*, 493 U.S. 521, 525 n.2, 528 (1990); *Heckler* v. *Campbell*, 461 U.S. 458, 466 (1983). In such a situation, regulations must be sustained unless they are "arbitrary, capricious, or manifestly contrary to the statute." *Sullivan* v. *Zebley*, 493 U.S. at 528 (quoting *Chevron*, 467 U.S. at 843-844). Here, far from being arbitrary or capricious, the readuit regulation is eminently reasonable and fully consistent with the Act.

A. Section 1395ww(h)(2)(A) Is Ambiguous With Respect To The Manner In Which The Secretary May Calculate For The Base Year An Average Per-Resident Amount Of GME Costs

1. *The Secretary's approach is consistent with the text of Section 1395ww(h)(2)(A)*

The GME Amendment provides that, for all cost years beginning on or after July 1, 1985, the determination of GME costs reimbursable under Medicare Part A is based on the amount of a provider's average per-resident GME costs for the base year, updated for inflation and multiplied by the number of the hospital's current full-time-equivalent residents and its Medicare patient load. 42 U.S.C. 1395ww(h)(3). The GME Amendment directs the Secretary to calculate the per-resident amount by dividing the amount of GME costs "recognized as reasonable" under the Medicare Act for the base year (numerator) by the number of full-time-equivalent residents working at the hospital in the base year (denominator). 42 U.S.C. 1395ww(h)(2)(A). Despite the obvious significance of a hospital's "reasonable" base-year GME costs, Congress did not specify the manner by which the Secretary should determine those costs. Instead, the GME Amendment simply provides, in general

terms, that the Secretary "shall determine" the average amount recognized as reasonable. *Ibid.*

The language at issue in this case—"recognized as reasonable under this subchapter"—is amenable to at least two different constructions. See *Tulane*, Pet. App. 48a ("[T]he relevant phrase 'amount recognized as reasonable under this subchapter' *is* on its face ambiguous."). The Secretary interprets the phrase to mean that the determination of the average amount of a provider's reasonable base-year GME costs must be consistent with the reasonableness standards in effect during the base year under the Medicare Act and implementing regulations. Under that construction, the Secretary may compute an average per-resident base-year amount that is "recognized as reasonable under this subchapter" by reauditing hospitals' cost reports for the base year to ensure that the base-year costs comport with the reasonableness standards of the Medicare Act in effect during the base year. In that manner, misclassified or nonallowable costs paid to providers in the base year do not continue to be paid in future years. Petitioner argues (Br. 19-23), by contrast, that the amount of base-year GME costs "recognized as reasonable under this subchapter" must mean the amount of GME costs that were included in the hospital's NPR (or a subsequent PRRB decision) for the base year, if that intermediary determination (or PRRB decision) is not subject to reopening under the three-year period prescribed by the Secretary's regulations, 42 C.F.R. 405.1807 and 405.1885(a). In petitioner's view, Congress by statute intended to prohibit the Secretary from reauditing base-year GME costs if the reopening period prescribed by mere regulation had expired with respect to the base year. Under that construction, any errors

in base-year reimbursements must be permanently carried forward by the Secretary in reimbursements for GME costs in all subsequent years. Nothing in the GME Amendment compels that anomalous result.

In requiring the Secretary to reimburse GME costs under the new methodology, Section 1395ww(h)(2)(A) requires the Secretary to consider only those base-year GME costs "recognized as reasonable" under the Medicare Act. It does not prescribe, however, what costs should be "recognized as reasonable," how the Secretary should ascertain those costs, or when the reasonableness of the costs should be regarded as "recognized." At bottom, "Congress has not directly addressed the precise question at issue" (*Chevron*, 467 U.S. at 843)—whether Congress intended for the Secretary to reach her determination of reasonable costs by using an amount that already had been reimbursed by the Secretary in the base year, or by using an amount that the Secretary now determines should be recognized as reasonable under base-year cost principles. As the D.C. Circuit observed in *Tulane*, "[t]he statutory text certainly does not address this administrative dilemma directly," and there is "no convincing evidence, direct or indirect, that Congress meant to prohibit corrective reauditing of the 1984 GME cost figures." Pet. App. 46a.[8]

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[8] In disagreeing with the D.C. Circuit's conclusion in *Tulane* that the text of the GME Amendment is ambiguous, the Sixth Circuit in *Toledo* expressed the view that "*Chevron* instructs courts to accept a reasonable administrative interpretation of a statute" only when "Congress *intentionally* leaves gaps and ambiguous terms in a statute for the agency to flesh out." Pet. App. 29a (emphasis added). As the Court in *Chevron* made clear, however, courts should accord deference to reasonable policy choices that "Congress itself either *inadvertently* did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities." 467 U.S. at 865-866 (emphasis added). Thus, the proper inquiry is whether Congress, in enacting the GME Amendment, unambiguously expressed its intent to prohibit the Secretary from correcting past errors in administratively settled cost years.

Petitioner similarly argues (Br. 29 n.9) that "the error of the Secretary's construction" is demonstrated by the absence of legislative history indicating that Congress specifically intended for the Secretary to correct for errors in the GME base year after expiration of the reopening period under Section 405.1885(a). This Court, however, has rejected that contention. See *Chevron*, 467 U.S. at 862 (noting that legislative history of 42 U.S.C. 7502(b)(6) (1982) is "unilluminating" and "silent on the precise issue before us").

The ambiguity in the statutory phrase "amount recognized as reasonable under this subchapter" stems from Section 1395ww(h)(2)(A)'s use of the past participle "recognized." As the D.C. Circuit in *Tulane* explained, that term permits "alternative temporal readings." Pet. App. 49a (quoting *United States Dep't of Treasury* v. *FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992)); see also Bergen Evans & Cornelia Evans, *A Dictionary of Contemporary American Usage* 353 (1957) ("the form [of past participles] itself does not express time and may be used in speaking of the present"). Thus, "it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three-year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be 'recognized as reasonable under this title' at a later time after more careful assessment." *Tulane*, Pet. App. 48a-49a.

Other provisions of the Medicare Act similarly use the phrase "recognized as reasonable" in a way that highlights its flexibility. See 42 U.S.C. 1395x(v)(1)(A) (permitting the Secretary to "provide for the establishment of limits [of certain costs] *to be* recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services" (emphasis added)) (discussed in *Good Samaritan Hospital*, 508 U.S. at 412); 42 U.S.C. 1395uu(c)(1)(B) (providing that a hospital's "transitional allowance" with respect to the closing or converting of underutilized hospitals "shall recognize" "the outstanding portion of actual debt obligations *previously* recognized as reasonable for purposes of reimbursement under this subchapter" (emphasis added)). As the D.C. Circuit observed in *Tulane*, those provisions "suggest that the phrase 'recognized as reasonable,' by itself, does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken. Context is all, and in this case, * * * the use of the 1984 figures for the indefinite future cautions us against a reading of the phrase that allows no elbow room for adjustments based on prior miscalculations or errors." Pet. App. 49a-50a.

Indeed, petitioner concedes that the word "recognized" is temporally indefinite in this setting. When Congress enacted the GME Amendment in April 1986, most NPRs for fiscal year 1984 were still subject to reopening under the Secretary's regulations. Petitioner therefore agrees that, in directing the Secretary to determine an amount of base-year GME costs "recognized as reasonable," Section 1395ww(h)(2)(A) does not refer to just those GME costs that were *previously* reflected in the hospital's

base-year cost report or NPR and were already reimbursed by the Secretary. See Br. 22; see also *Toledo*, Pet. App. 30a ("[T]he use of the past participle 'recognized' does not restrict the Secretary to using numbers that had been finally determined prior to the passage of the GME amendment, as all of the base-year determinations were still subject to administrative reopening in 1986."). Petitioner's acknowledgement that the phrase "recognized as reasonable under this subchapter" is not restricted to *previously* reimbursed costs makes clear that the statutory text permits the Secretary to reexamine base-year costs in implementing the GME Amendment. Nothing in the text of that phrase prohibits the Secretary from pursuing the particular manner she has chosen for conducting that reexamination.

The structure of the GME Amendment, and of the Act as a whole, supports the Secretary's approach in other respects as well. The most natural reading of the GME Amendment's mandate to determine an average amount of base-year GME costs "recognized as reasonable under this subchapter" is that the phrase "under this subchapter" modifies the word "reasonable," which immediately precedes it. In other words, a hospital may obtain reimbursement for GME costs only if they are reasonable within the meaning of the Medicare Act. See, *e.g.*, 42 U.S.C. 1395f(b)(1). Although the Act does not prescribe specific procedures for calculating reasonable costs, Congress has granted the Secretary broad authority to promulgate regulations setting forth the methods to determine reasonable costs and the items to be included in reimbursable services. 42 U.S.C. 1395x(v)(1)(A), 1395hh(a)(1); see also 42 U.S.C. 405(a) (as incorporated by 42 U.S.C. 1395ii), 1302(a). That authority

permits the Secretary to promulgate the reaudit regulation to ensure that future payments for GME costs do not include unreasonable costs previously paid to hospitals.[9]

Moreover, by providing that the Secretary "shall determine" an average amount of base-year GME costs recognized as reasonable under the Medicare Act, the GME Amendment reflects Congress's expectation that the Secretary would, in the future, make a fresh determination of reasonable base-year GME costs, whether under existing, revised, or new regulations. As the D.C. Circuit in *Tulane* explained, the phrase "shall determine" is "activist language suggest[ing] that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations." Pet. App. 49a n.6.[10] Further, given the statu-

[9] Arguing that the Secretary "seems to be searching for a statutory basis * * * to issue the reaudit regulation," petitioner asserts (Br. 26 n.8) that the Secretary "expressly disavowed reliance on her general rulemaking authority" under Section 1395hh(a)(1) to support the reaudit regulation. The only support for that contention, however, is petitioner's reference to the Secretary's statement in the preamble to the final rule that "the agency is not relying on our general grant of rulemaking authority to support *retroactive application*" of the GME Amendment to cost-reporting periods beginning on or after July 1, 1985, "but, rather, on a specific congressional enactment, that is, [the GME Amendment]." 54 Fed. Reg. 40,314 (1989) (emphasis added). Moreover, the Secretary *expressly* relied on her general rulemaking authority in promulgating the reaudit rule. See *id.* at 40,315 (citing, *inter alia*, 42 U.S.C. 1302, 1395x(v), 1395hh, and 1395ww); see also 42 C.F.R. 413.86 (citing 42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

[10] Petitioner argues (Br. 21 n.6) that "determine" is only an "activist" word under an "activist" construction of the Act.

tory directive to create a new payment methodology that would govern subsequent payments for GME costs, the Secretary reasonably found it "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). Accordingly, the Secretary's decision to implement the new payment methodology by reauditing base-year costs to ensure that only reasonable costs are included in the base for future years is entirely consistent with the statutory directive to determine an amount "recognized as reasonable" under the Medicare Act.

2. *Petitioner's contention that the text of Section 1395ww(h)(2)(A) forecloses the Secretary's approach is without merit*

In contending that the phrase "amount recognized as reasonable under this subchapter" is unambiguous, petitioner relies not on the quoted words, or on other statutory text. Instead, petitioner relies principally

According to petitioner (*ibid.*; emphasis omitted), the directive in the GME Amendment to "determine" an average base-year per-resident amount by dividing base-year GME costs "recognized as reasonable" by the number of base-year full-time equivalent residents "does not authorize the Secretary to redetermine" those base-year costs. As explained above, however, the statutory language "recognized as reasonable under this subchapter" is temporally ambiguous and does not clearly refer to any particular methodology or point in time for recognizing reasonable base-year GME costs. Moreover, in observing that the GME Amendment used "activist language," *i.e.*, not passive terminology, in directing the Secretary to "determine" an amount of reasonable base-year GME costs, the *Tulane* court meant only that "it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula." Pet. App. 49a n.6.

(Br. 18-23) on regulations issued by the Secretary, 42 C.F.R. 405.1885(a) and 405.1807, under which a final determination of the total amount of reimbursement due for a given cost year may be reopened only within three years of that final determination. Thus, in petitioner's view, if the final determination of the total amount of reimbursement due a particular hospital for the 1984 cost year was made more than three years earlier, the reasonable costs for that year are altogether immune from reexamination, even if the reexamination occurs solely to determine a reasonable foundation for GME reimbursements in future years. Nothing in the phrase "recognized as reasonable," or elsewhere in the text or legislative history of the GME Amendment, however, suggests that Congress meant to import a mere regulatory limitation into the GME Amendment itself.

The fact that the three-year limitation on reopening on which petitioner relies is not mandated by the Act, but is imposed only by regulation, is significant for another reason as well. Even under petitioner's theory, the Secretary could have achieved the same result as that provided for under the reaudit regulation by expressly amending the reopening regulation to lengthen the reopening period for base-year GME costs solely for purposes of determining the proper amount of reimbursement due in subsequent years under the GME Amendment, without disturbing the amount of reimbursement that the provider already had received for services that were rendered in the base year. Compare 42 C.F.R. 413.86(e)(1)(iii) ("If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the

per resident amount.").[11] If that special treatment of GME costs from the usual operation of the reopening limitation under the regulations would not violate the GME Amendment, there is no reason why the approach taken by the Secretary—which is identical in substance—should be regarded as fundamentally inconsistent with the Amendment.

Petitioner also argues (Br. 23-26) that, had Congress intended the Secretary to adopt a new rule defining reasonable base-year costs, Congress explicitly would have provided for such authority in the GME Amendment as it did with respect to other matters, such as the determination of full-time-equivalent residents in Section 1395ww(h)(4). By the time the GME Amendment was enacted, however, the Secretary's authority to promulgate regulations defining the methodology for determining reasonable costs was already established in the Medicare Act. See 42 U.S.C. 1395x(v)(1)(A), 1395hh(a)(1); *Good Samaritan Hospital*, 508 U.S. at 412. As the D.C. Circuit observed in *Tulane*, because "the concept of reasonable costs already was a mainstay of Medicare statutes and regulations, * * * there was no need to establish any new rulemaking authority for its determination." Pet. App. 47a n.5.

In Section 1395ww(h)(4)(A), by contrast, Congress addressed a new issue and provided that the Secretary

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[11] Indeed, in promulgating the reaudit rule, the Secretary effectively lengthened the reopening period under Section 405.1885(a) for the benefit of hospitals so that they could request a redetermination of their operating costs in the event that the GME reaudit revealed that previously claimed costs should have been classified as operating costs. See 54 Fed. Reg. 40,300-40,302 (1989); 42 C.F.R. 413.86(j)(1)(i); see also note 4, *supra*.

"*shall* establish rules" for the computation of the number of full-time-equivalent residents in an approved program. Thus, Congress did not merely "authorize" the Secretary to adopt such rules, as petitioner maintains (Br. 23); Congress required that action. Congress's decision to include a new statutory *mandate* to issue rules in that one instance in no way suggests that Congress intended to eliminate the Secretary's preexisting statutory authority to issue procedural and substantive rules for reexamining reasonable costs in other situations. Nor is there anything else in the text or legislative history of the GME Amendment suggesting that Congress intended to restrict the Secretary's authority to issue new regulations for the purpose of determining reasonable base-year GME costs. For those reasons, the Secretary correctly interpreted the GME Amendment to permit the issuance of a new rule to govern reaudit of base-year GME costs to eliminate nonallowable or misclassified costs under the new reimbursement methodology to be applied in future years.[12]

Petitioner similarly contends (Br. 27-29) that, had Congress intended the Secretary to reexamine the reasonableness GME costs in the base year, the GME

[12] Petitioner further argues (Br. 32-34) that the Secretary purports to derive authority to issue the reaudit rule simply from the GME Amendment's failure expressly to prohibit the Secretary from reauditing base-year costs. That is incorrect. The reaudit rule is an application of the Secretary's broad authority under the Medicare Act to promulgate regulations to establish procedures and methods of proof (42 U.S.C. 405(a), as incorporated by 42 U.S.C. 1395ii) and to define reasonable costs (42 U.S.C. 1395x(v)(1)(A), 1395hh). The Secretary's decision to invoke that preexisting authority in this situation, moreover, is reinforced by the purpose of the GME Amendment. See also note 8, *supra*.

Amendment would have addressed various administrative issues associated with implementation of the reaudit rule, such as the cost principles to be applied and the availability of adequate documentation to conduct the reaudits. That contention, however, presupposes that Congress knew that the Secretary's prior reimbursements for GME costs contained substantial overpayments and that, based on the knowledge of those prior errors, Congress would have dictated a specific methodology for the reaudits. Given that neither the text nor the history of the GME Amendment reveals Congress's views on the subject, the Secretary considered the matter "not in a sterile textual vacuum, but in the context of implementing policy decisions in a technical and complex arena," *Chevron*, 467 U.S. at 863, and accordingly fashioned the reaudit regime consistent with the Secretary's responsibilities for administering the Medicare Act. See 42 U.S.C. 1395h(a) (authorizing the Secretary to use fiscal intermediaries "to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part"); 42 C.F.R. 421.100(c) (describing audit function of intermediaries). Accordingly, "since the GME Amendments were enacted for the purpose of establishing a new and presumably more accurate methodology for reimbursing GME costs, the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments." *Tulane*, Pet. App. 46a.

Petitioner also errs in contending (Br. 30-32) that the reaudit regulation conflicts with the principle that "identical words used in different parts of the

same act are intended to have the same meaning." *Sorenson* v. *Secretary of Treasury*, 475 U.S. 851, 860 (1986). Petitioner points to two provisions of the Medicare Act limiting reimbursable costs to a base year that the Secretary chose not to subject to a mandatory reaudit. Those provisions, however, do not contain language identical to the GME Amendment.[13] In any event, those provisions address different contexts under the Medicare program, and the fact that the Secretary, as a matter of policy, did not consider a reaudit necessary for base-year calculations in those other contexts does not mean, as petitioner contends, that the phrase "recognized as reasonable under this subchapter" unambiguously forecloses such reaudits where, as here, the Secretary does consider them to be necessary. *Samaritan Health Sys.* v. *Shalala*, No. Civ. 95-1032 (D. Ariz., Aug. 15, 1997), slip. op. 12 (rejecting the same objection to the reaudit regulation, on the ground that

[13] Compare 42 U.S.C. 1395ww(h)(2)(A) ("The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.") with 42 U.S.C. 1395ww(a)(1)(C) ("The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services * * * recognized under this subchapter for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.") and 42 U.S.C. 1395ww(b)(3)(A)(i) ("[T]he term 'target amount' means, with respect to a hospital for a particular 12-month cost reporting period * * * in the case of the first such reporting period * * *, the allowable operating costs of inpatient hospital services * * * recognized under this subchapter for such hospital for the preceding 12-month cost reporting period.").

"there is nothing inconsistent about reacting to different situations differently"); see also *Chevron*, 467 U.S. at 864 ("[T]he fact that the agency has adopted different definitions in different contexts adds force to the argument that the definition itself is flexible.").[14]

B. The Reaudit Regulation Is Reasonable

For the reasons set forth in Point A, the text of Section 1395ww(h)(2)(A) is ambiguous and does not, on its face, bar the Secretary from implementing the GME Amendment in the way that she did. A court interpreting an ambiguous provision of a statute

[14] Petitioner suggests (Br. 15, 31) that the Secretary's reaudit rule conflicts with the D.C. Circuit's decision in *Georgetown University Hospital* v. *Bowen*, 862 F.2d 323 (1988) (*Georgetown II*). In fact, however, the Secretary's reaudit rule completely accords with the *Georgetown II* decision. That case involved the Secretary's implementation of Section 1395ww(b)(3)(A)'s direction to the Secretary to determine hospital-specific rates for the four-year PPS transition period calculated on the basis of a base year. The court invalidated HHS's regulation providing that, when a hospital successfully challenged an intermediary's estimation of the base-period costs, the finally approved figure would not be applied to the year being challenged. 862 F.2d at 325. The court in *Georgetown II* held that the phrase "allowable operating costs * * * recognized under this subchapter" in Section 1395ww(b)(3)(A) requires HHS to apply a final administrative or judicial decision on the allowability of particular costs to the year under appeal. *Id.* at 326-328. As the D.C. Circuit later explained in *Tulane*, "HHS is in no way attempting here to 'effectively cement[] unlawful calculations * * * by largely insulating them from review,' as it was in *Georgetown II*. Just the opposite. It is attempting [in the reaudit rule] to ensure that misclassified and nonallowable costs approved in NPRs for 1984 are *not* cemented indefinitely into future GME cost reimbursements." Pet. App. 48a (citation omitted).

administered by an agency must defer to the agency's interpretation if that interpretation is "reasonable." *Chevron*, 467 U.S. at 844. As this Court has explained, "when an agency is charged with administering a statute, part of the authority it receives is the power to give reasonable content to the statute's textual ambiguities." *Department of Treasury* v. *FLRA*, 494 U.S. 922, 933 (1990). "That is a task infused with judgment and discretion, requiring the 'accommodation of conflicting policies that were committed to the agency's care.'" *Ibid.* The principle of deference to administrative interpretations

> has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations.

Chevron, 467 U.S. at 844. Judicial deference is particularly warranted when, as here, the statute establishes "a complex and highly technical regulatory program," in which eligibility determinations "necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley* v. *BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991); see also *Thomas Jefferson University* v. *Shalala*, 512 U.S. 504, 512 (1994). The Secretary's decision to implement the GME Amendment by reexamining base-year GME costs to ensure that they include only reasonable costs reflects the expert agency's interpretation and implementation of an ambiguous provision of a complex statute. The reaudit regulation attempts to reconcile the Secretary's existing regulatory regime with the obvious desire of Congress that the GME Amendment's new payment methodology would be based on "reasonable" base-year costs, 42 U.S.C. 1395ww(h)(2)(A). The only remaining inquiry is whether the agency's interpretation is "based on a permissible construction of the statute." *Auer* v. *Robbins*, 117 S. Ct. 905, 909 (1997) (quoting *Chevron*, 467 U.S. at 842-843).

To answer that inquiry, a court should examine whether the agency's interpretation is "reasonable," *Pauley*, 501 U.S. at 699, in the sense that it is "rational and consistent with the statute." *Sullivan* v. *Everhart*, 494 U.S. 83, 89 (1990) (quoting *NLRB* v. *United Food & Commercial Workers Union, Local 23*, 484 U.S. 112, 123 (1987)). Indeed, that approach not only gives proper respect to the agency's congressionally assigned function, but it also confines the courts to their proper role by directing disputes over policy to the politically accountable branches of government. *Chevron*, 467 U.S. at 864-865. That approach is especially appropriate here, because the text of the statutory provision does not purport to address, much less strike a balance between, administrative finality and ensuring that unreasonable and misclassified costs are not perpetuated in future reimbursements to Medicare providers.

1. ***The Secretary's regulation furthers the purpose of the GME Amendment***

The Secretary's interpretation of the GME Amendment is manifestly rational. Section 1395ww(h) establishes a new payment methodology for reimbursing GME costs. Under that new methodology, a hospital's base-year GME costs significantly influence Medicare payments for GME costs in all subsequent years, regardless of the hospital's actual GME costs

incurred in those years.[15] The Secretary thus proposed reauditing base-year GME costs to ensure that those costs are "an accurate reflection of legitimate GME costs incurred during the * * * base period." 53 Fed. Reg. 36,591 (1988). The Secretary reasoned that "it is very important that inappropriate costs not be included in the base-period amount." *Ibid.* The Secretary therefore adopted the reaudit rule so that the "average amount recognized as reasonable" for the base year does not include improperly classified or nonallowable costs that would be perpetuated as overpayments in future reimbursements to hospitals. See *id.* at 36,591-36,592; 54 Fed. Reg. 40,301 (1989).

Further, since the Secretary reasonably found it "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely," 54 Fed. Reg. 40,301 (1989), it was reasonable for the Secretary to adopt an approach that would minimize the chance of carrying forward past errors. That interpretation clearly furthers the purpose of the GME Amendment to "*limit payments* to hospitals for their direct costs of approved medical education activities"

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[15] Although Congress has made minor adjustments to the GME Amendment, it has left unchanged its basic methodology of reimbursing GME costs based on the reasonable costs incurred by the provider in the base year. See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13563(a) (updating per-resident amounts), § 13563(b) (amending definition of initial residency period), § 13563(d) (requiring adjustments to base-year GME costs for certain hospitals that did not pay Federal Insurance Contribution Act (FICA) taxes during the base year), 107 Stat. 605-606; see also Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4623 (revising method for counting residents), § 4627 (addressing counting of residents in combined residency programs), 111 Stat. 477-478, 483.

after the effective date of the GME Amendment. H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 482 (1985) (emphasis added). See *Tulane*, Pet. App. 51a ("The agency's belief that Congress would resist permanently ingraining misclassified and nonallowable costs in future reimbursements to health care providers can hardly be deemed unreasonable or inconsistent with the congressional purpose of erecting a new and more accurate reimbursement methodology."). By contrast, petitioner's view perpetuates the payment of misclassified and nonallowable costs and would frustrate the purpose of the GME Amendment to limit reimbursement to "reasonable" base-year GME costs.

The Secretary's approach utilizes data and legal principles from the base year, but subject to a readuit of those data to determine whether the applicable legal principles were properly applied. That approach is consistent with the intent of the conferees of the 1986 Act that "[h]ospital-specific approved FTE resident amounts will be determined based on data on direct graduate medical education (GME) costs and numbers of interns and residents, from hospital cost reporting periods beginning in fiscal year 1984." H.R. Conf. Rep. No. 453, *supra*, at 484. Thus, the Secretary's construction of the GME Amendment as reflected in the reaudit rule "closely fits 'the design of the statute as a whole and . . . its object and policy.'" *Good Samaritan Hospital*, 508 U.S. at 418 (quoting *Crandon* v. *United States*, 494 U.S. 152, 158 (1990)).

Contrary to petitioner's suggestion (Br. 40-41), the Secretary had reason to believe that providers' base-year GME reimbursements reflected significant overpayments. The Secretary was particularly concerned

that, "in the past, there have been some questionable [misclassified and nonallowable] costs erroneously reimbursed through the direct medical education pass through." 53 Fed. Reg. 36,591 (1988).[16] For instance, the Secretary noted "several situations * * * in which physicians' costs incurred for activities unrelated to GME, malpractice costs, and medical library costs have been misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center." 54 Fed. Reg. 40,300 (1989). The Secretary further explained that "GME costs were not given sufficient scrutiny at the time because of the many changes that were taking place in Medicare generally," including the fact that the GME base period was also the first cost-reporting period under the new PPS methodology. *Id.* at 40,301. Moreover, the GME Amendment introduced a new statutory concept of per-resident GME costs, which caused the Secretary "to examine GME costs that have been reimbursed in the past and to question the

[16] The Secretary explained (1) that misclassified costs are "those costs that were treated as allowable GME costs but that if properly classified would be considered allowable operating costs, such as physicians' compensation costs for services to the hospital that are not specifically and directly related to approved educational activities"; and (2) that examples of nonallowable costs include "the costs of a medical school related to a hospital by common ownership or control * * * that are not directly and specifically related to patient care furnished in the hospital, and physician compensation costs that a hospital claims with respect to services furnished to individual patients that should be paid on a Part B reasonable charge basis." 53 Fed. Reg. 36,591-36,592 (1988).

significant variation in costs that have been allowed." 53 Fed. Reg. 36,593 (1988).[17]

Indeed, the application of the reaudit rule to petitioner aptly illustrates that the Secretary was correct in the belief that hospitals had received excessive payments for GME costs in the base year, and that a reaudit was necessary to correct those errors for purposes of implementing the new payment methodology for future years. Petitioner's original NPR for the 1984 cost year reflected GME costs of $9,892,644. The reaudit revealed that only $5,916,868 of that amount should be recognized as reasonable under the cost-reimbursement standards applicable in 1984. See note 6, *supra*. Thus, the reaudit showed that $3,975,776—approximately 40%—of petitioner's GME reimbursement for the base year had been misclassified or nonallowable. It was clearly rational for the Secretary to construe the GME Amendment to permit a reaudit of costs paid to hospitals such as petitioner to prevent them from receiving unreasonable and profligate payments in the indefinite future.

Petitioner's response (Br. 40-42) to the fact that many hospitals received excessive GME costs in the base year is that the Secretary should have gotten it right the first time, or acted more quickly in promul-

[17] Petitioner is correct in noting (Br. 42 n.17) that the range in base-year per-resident amounts identified by the Secretary, which ranged "from below $10,000 to over $100,000 per resident," may have been due to many factors, including different billing practices. See 53 Fed. Reg. 36,593 (1988). At the time the Secretary proposed the reaudit rule, however, the Secretary reasonably "believe[d], based on situations that have been brought to [HHS's] attention, that misclassification of costs and questionable physician allocation agreements [we]re contributing factors" to the vast discrepancies in per-resident amounts. *Ibid.*

gating the reaudit rule so that the reaudits could have taken place within the three-year reopening period under 42 C.F.R. 405.1885(a). Petitioner believes that the failure to have acted more quickly after enactment of the GME Amendment in April 1986 requires that uncontroverted errors in 1984 reimbursements be perpetuated in future years. Neither the Secretary's delay nor the initial failure to correct errors, however, justifies a reading of the Amendment that would prevent the Secretary from remedying that problem in the future by declining to carry forward impermissible and unreasonable costs.

In any event, the three-year time period between enactment of the GME Amendment and the promulgation of the final GME regulation "was not an unreasonable period for developing, proposing, permitting comment, and finalizing a regulatory framework for a complex statutory scheme." *Tulane*, Pet. App. 51a-52a. As petitioner acknowledges (Br. 23-26 & n.7), the GME Amendment includes a number of provisions that made it necessary for the Secretary to develop new and complex regulations. Thus, the Secretary's regulations implementing the GME Amendment, including the reaudit rule, required extensive analysis. See 53 Fed. Reg. 36,589-36,608 (1988). The Secretary's final regulations, which differed in several respects from the proposed regulations, were the product of the Secretary's careful consideration of the statutory provisions and the issues raised during the rulemaking proceeding. See 54 Fed. Reg. 40,286-40,319 (1989). Accordingly, the Secretary's delay in implementing the GME Amendment does not render the Secretary's construction unreasonable.

2. *The 1990 amendments to the Act that phased in recoupments under the Secretary's GME regulation reinforce the validity of the Secretary's approach*

Congress has, by statute, specifically recognized the Secretary's implementation of the GME Amendment and, far from disapproving that implementation, has instead chosen only to mitigate its financial impact. In the Omnibus Budget Reconciliation Act of 1990 (OBRA), Pub. L. No. 101-508, § 4004(a)(1), 104 Stat. 1388-39 (42 U.S.C. 1395ww note), Congress provided that the Secretary was prohibited, until October 1, 1991, from recovering GME overpayments accrued during cost-reporting years 1985 through 1991 resulting from the new payment methodology of the GME Amendment. The OBRA also limited the Secretary's recovery of those accrued overpayments to 25% of the amount of the overpayments in each of the succeeding four fiscal years. § 4004(a)(2), 104 Stat. 1388-39.

Petitioner contends (Br. 34-35 n.16) that the 1990 legislation does not reflect approval of the Secretary's policy as reflected in the reaudit rule because Congress did not refer to that policy and because the reaudits had not yet been completed by the time Congress enacted OBRA. The Secretary's reaudit rule, however, was promulgated more than a year before the 1990 legislation was enacted, and the legislative history makes clear that Congress was fully aware of the Secretary's implementation of the GME Amendment. The House Report on the

bill in which the GME recoupment limitation originated explained:

> *Section 3102. Hospital Physician Education Recoupment*
>
> *Present Law.*—The Consolidated Omnibus Reconciliation Act (COBRA) limited payment for the direct costs of graduate medical education to an average amount per full time equivalent resident physician updated by the Consumer Price Index. In order to determine the average per resident amount, the Secretary has directed fiscal intermediaries to conduct audits of hospitals to assure that the amount of cost reported is accurate. Some of the audits have identified overpayments to hospitals for graduate costs.
>
> *Proposal.*—The Department would be prohibited from making any recoupments relating to GME in fiscal year 1991. The recoupments would then be made over a four year period, with one-quarter of the amount due from each institution payable in each of the four fiscal years beginning with 1992.
>
> *Effective Date.* — October 1, 1990.

H.R. Rep. No. 899, 101st Cong., 2d Sess. Pt. 1, at 138 (1990).[18] The Conference Report similarly stated:

> The conferees note that the Secretary has recently begun to implement the graduate medical education policy enacted in COBRA 85. The conferees expect the Secretary to recoup overpayments identified as a result of implementing this policy over a four year period, after a one year delay. The Secretary may not recoup more than 25 percent of the total amount of such overpayments from a hospital during each of four fiscal years. Nothing in this provision should be construed to require the Secretary to continue to make such overpayments to such hospitals after the initial identification of such an overpayment.

[18] Section 3102 was part of H.R. 5828, 101st Cong., 2d Sess. (1990), the language of which was added as a floor amendment in the House to H.R. 5835, 101st Cong., 2d Sess. (1990), the bill that was ultimately enacted as OBRA 1990. See 136 Cong. Rec. H10,297, H10,323 (daily ed. Oct. 16, 1990).

H.R. Conf. Rep. No. 964, 101st Cong., 2d Sess. 719 (1990). Congress therefore plainly intended that the Secretary was not required to continue making "overpayments" in future years where an audit had disclosed errors in the base year.

3. *The Secretary's approach is fair and consistent with other reimbursement principles*

a. Petitioner contends (Br. 22-23, 35-40) that the Secretary's reaudit rule conflicts with principles of issue preclusion and fundamental fairness because the reaudits "set aside" (Br. 35, 36) cost determinations for the base year that have become final under the Secretary regulations. See 42 C.F.R. 405.1807, 405.1885(a). That contention, however, overlooks the fact that the reaudits authorized by the Secretary's GME regulation may not be used to recoup erroneous reimbursements for GME costs in any cost-reporting period that is administratively final. See 42 C.F.R. 413.86(e)(1)(iii). The reaudit rule therefore does not upset a final determination with respect to any closed cost-reporting year. Because the Secretary is not attempting to recover payments from administratively settled years, there is nothing in the Secretary's other regulations that prohibits the Secretary from redetermining reasonable GME costs in the base year

for other purposes. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 17 ("Th[e] readjusted number does not affect past reimbursements, for those reimbursements are 'final.' Rather, the corrected number will only be applied in cost reporting years still subject to reopening. * * * This does not violate principles of issue preclusion.").[19]

Similarly, it is plainly rational for the Secretary to prevent hospitals such as petitioner from receiving overpayments in subsequent cost years and in cost years still subject to reopening under Section 405.1885(a). Hospitals certainly have no cognizable expectation with respect to future payments or payments still subject to reopening under the Secretary's regulations.[20] In other words, even if petitioner

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[19] Petitioner's issue-preclusion argument is further undermined where, as here, reimbursement of GME costs in the base year was based on an intermediary's determination in an NPR, without a hearing before the PRRB on the reasonableness of the costs. In those circumstances, the issue of the reasonableness of base-year GME costs would not have been actually litigated in a proceeding of sufficient adversariness and formality to trigger general principles of issue preclusion. See Restatement (Second) of Judgments § 27 & cmt. e, § 28(5) & cmts. c, i, § 83 (1982); cf. *Thomas Jefferson University*, 512 U.S. at 517 (declining to bind the Secretary to a cost determination previously made by an intermediary).

[20] Petitioner contends (Br. 39-40) that "[t]here is a fundamental inconsistency" between the Secretary's reaudit rule and instances in which the Secretary has decided to apply judicial decisions on a prospective basis and to all pending administrative challenges, but not to settled cost reports. See HCFA Ruling 89-1, Medicare and Medicaid Guide (CCH) ¶ 37,614 (1989); HCFA Ruling 97-2, Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997). That argument is without merit. In cases in which the law has changed by judicial decision, the Secretary reasonably has declined to accord retroactive relief

were correct in suggesting (Br. 37) that the three-year reopening period prescribed by Section 405.1885(a) "is the functional equivalent of a statute of limitations," the reaudit regulation neither extends that period nor alters hospitals' legitimate expectations.

This case illustrates the fact that the reaudit rule does not upset providers' settled expectations. Although the 1991 reaudit of petitioner's base-year GME costs demonstrated that petitioner received an excess reimbursement of $3,975,776 due to errors in the original cost report and NPR, the reaudit rule prohibits the Secretary from recouping that amount because more than three years have passed since the

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when the law applicable at the time of the intermediary's decision comported with the Secretary's construction of the Medicare Act, which the provider never challenged on direct administrative appeal. See 42 C.F.R. 405.1885(b) (providing that settled cost reports will be reopened within the three-year period when the Health Care Financing Administration (HCFA) notifies the intermediary that its prior determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]"); cf. *Reynoldsville Casket Co.* v. *Hyde*, 514 U.S. 749, 758 (1995) ("New legal principles, even when applied retroactively, do not apply to cases already closed."); *ICC* v. *Brotherhood of Locomotive Engineers*, 482 U.S. 270, 277-278 (1987) (failure of ICC to reopen proceeding as permitted by 49 U.S.C. 10327(g) because of substantially changed circumstances or new evidence is reviewable only for abuse of discretion). When the GME Amendment was passed in 1986, and until the Secretary issued the GME regulation in 1989, however, hospitals continued to be reimbursed based on their reasonable costs actually incurred. Those payments for GME costs necessarily were conditional, because they were inconsistent with the GME payment methodology imposed by the GME Amendment. Thus, providers could have had no legitimate settled expectation as to payments that were made during that period and that were subject to the Secretary's three-year reopening rule.

original determination. Thus, to the extent that petitioner expected its reimbursable base-year GME costs to be "final and binding" under Section 405.1807 on the date that the three-year period expired under Section 405.1885(a), that expectation has been fully realized. By contrast, petitioner has no legitimate expectation that base-year errors resulting in overpayments will be carried forward into the indefinite future. The reaudit rule does nothing more than prevent such abuse from occurring.

b. The reaudit rule is not invalid, as petitioner suggests (Br. 22, 27, 29, 36), because the reaudits occurred in 1990 and 1991, while hospitals were required to retain certain physician compensation allocation records relating to the 1984 base year for "at least four years after the end of [such] reporting period." 42 C.F.R. 405.481(g)(3) (1985). Before hospitals were permitted by regulation to destroy those records, the GME Amendment, enacted on April 7, 1986, put hospitals on notice that the new GME payment methodology would relate to the 1984 cost-reporting year; at the latest, the Secretary's proposed rule, issued on September 21, 1988, clearly notified hospitals of the Secretary's intention to reaudit base-year costs. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 13. Moreover, because some hospitals nonetheless had discarded records relating to physician cost and time allocation due to the passage of time, the Secretary responded with "an equitable solution" that permitted hospitals, during the reaudit, "to furnish documentation from cost reporting periods subsequent to the base period in support of the allocation of physician compensation costs in the GME base period." See 55

Fed. Reg. 35,990, 36,063 (1990). That flexible approach hardly can be deemed unreasonable.[21]

In any event, petitioner's speculation about particular matters of audit methodology does not warrant invalidating the Secretary's regulation on its face. The regulation permitted providers, including petitioner, to challenge the application of specific auditing principles in individual cases. See 42 C.F.R. 413.86(e)(1) (v). Hospitals dissatisfied with the Secretary's determination were permitted to seek judicial review of that determination. 42 U.S.C. 1395*oo*(f)(1); see, *e.g.*, *Good Samaritan Hospital* v. *Shalala*, 873 F. Supp. 1083 (S.D. Ohio 1994). Thus, the Secretary's regulation reasonably permits an avenue of redress for hospitals that may be prejudiced by the reaudit.[22]

c. Petitioner argues (Br. 43) that the Secretary's reaudit rule produces "inconsistent determinations" for base-year GME costs because the reaudit rule may produce a determination of a hospital's base-year GME costs that differs from the original audit. There is nothing irrational, however, about the fact that the reaudit rule produces a baseline amount of GME costs for future years that corrects for past mistakes by excluding unreasonable costs originally reimbursed by the Secretary. Moreover, the difference between

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[21] Even petitioner availed itself of the Secretary's "equitable solution." Because petitioner did not, even as an initial matter, maintain physician time records in the base year that reflected physician time for teaching medical students, it presented to the PRRB time studies it conducted in 1989 and 1990 to demonstrate the propriety of its allocation of GME costs for 1984. See Admin. Rec. 21-29.

[22] Because petitioner withdrew or settled all of its administrative challenges to the reaudit of its base-year GME costs, see note 6, *supra*, it does not contend that it has been prejudiced by the passage of time.

the amount yielded by the reaudit and the amount yielded by the original audit results from the different statutory commands and purposes at issue. At the time of the original audit, Congress instructed the Secretary to reimburse reasonable GME costs "actually incurred" in each year, subject to limitations of reasonableness. 42 U.S.C. 1395x(v)(1)(A). The annual determinations of GME costs in those prior years had no bearing on subsequent payments. The GME Amendment, however, instructed the Secretary to determine base-year GME costs that would affect payments for all cost periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h). For that reason, the Secretary reasonably construed the GME Amendment as permitting reexamination of base-year GME costs to ensure that those costs were in fact reasonable for purposes of subsequent payments. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 18 (finding that "two different, but equally 'allowable,' determinations of a hospital's base year GME costs is reasonable in light of the dramatic shift in cost reimbursement methodology rendered by the GME amendments").

d. Petitioner argues (Br. 43-44) that the reaudit regulation conflicts with cost classifications established under the PPS system for other hospital costs. Specifically, petitioner objects (Br. 44) that the regulation "retroactively repealed the consistency rule" set forth in 42 C.F.R. 412.113(b)(3). The Secretary's GME regulation, however, in fact conforms to that rule.

As noted above (see page 4, *supra*), the PPS reimbursement system for hospital inpatient operating costs took effect at the beginning of fiscal year 1984, while GME costs continued to be reimbursed on a

reasonable-cost basis until enactment of the GME Amendment in 1986. 42 U.S.C. 1395ww(a)(4), (d)(1)(A) and (h)(2). During the PPS four-year transition period, a progressively declining portion of the reimbursement was based on a hospital-specific rate derived from the hospital's actual costs in a given base year, and a gradually increasing portion was based on a federal rate reflecting regional and national standardized amounts. See 42 U.S.C. 1395ww(d)(1)(C). To prevent hospitals from obtaining double reimbursement for the same item of cost during the transition period, *i.e.*, by classifying an item as an operating cost in the PPS base year of 1983 but reclassifying that item as a GME cost in the subsequent transition years, the Secretary adopted the "consistency rule," 42 C.F.R. 412.113(b)(3). Under that rule, GME costs "must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate." *Ibid.* When the Secretary proposed to reaudit base-year GME costs to implement the GME Amendment, the Secretary realized that previously claimed GME costs might be reclassified as operating costs. The Secretary therefore provided in the reaudit regulation that a hospital could request an upward adjustment in its PPS hospital-specific rate if the reaudit resulted in a reclassification of certain GME costs as operating costs. 42 C.F.R. 413.86(j)(1). See note 4, *supra*.[23] At

[23] The reaudit rule is not unreasonable because, as petitioner suggests (Br. 45), some hospitals may not have been able to obtain an increase in the PPS hospital-specific rate because they lacked adequate documentation to demonstrate that a rate increase was warranted or because the reopening period under Section 405.1885(a) already had expired. Many hospitals

the same time, the Secretary amended the consistency rule to reflect the relief being provided to hospitals under the reaudit rule. 54 Fed. Reg. 40,315 (1989) ("Except as provided in 42 C.F.R. 413.86[j] * * *, the costs of medical education must be

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sought and received a higher PPS hospital-specific rate as a result of the Secretary's actions. In the example cited by petitioner (Br. 45), *Harrisburg Hospital* v. *Blue Cross and Blue Shield Association*, Medicare and Medicaid Guide (CCH) ¶ 44,419 (1996), which involved a hospital's attempt to adjust the PPS rate so that more GME costs could be included in the GME base year (see 42 C.F.R. 413.86(j)(2)), the Administrator of HCFA denied the hospital a rate adjustment, not because the hospital discarded relevant records or the reopening period had expired, but because the hospital originally did not consider later-disputed malpractice premium costs to be related to GME and apparently, as a consequence, failed to maintain documents relating to those costs during the GME base year, despite regulations requiring such documentation. See *Harrisburg Hospital*, ¶ 44,419, at 49,418 (citing 42 C.F.R. 413.20, 413.24). Indeed, the Medicare Act generally forbids payment unless the provider "has furnished such information as the Secretary may request in order to determine the amounts due such provider." 42 U.S.C. 1395g(a).

Similarly, petitioner is incorrect in suggesting (Br. 45) that the Secretary acted unreasonably in not adjusting the PPS federal rate to reflect reclassification of costs from education to operating. As the Secretary explained in issuing the reaudit rule, "it would be inappropriate to change all hospitals' prospective payments retroactively to take account of changes to a subset of teaching hospitals' costs. The prospective payment system * * * was designed to set payments in advance, and payment rates were established based on the best data available at the time." 54 Fed. Reg. 40,301 (1989). Moreover, because the federal rate was calculated based on data from the 1981 cost year (42 U.S.C. 1395ww(d)(2)(A); 48 Fed. Reg. 39,763-39,764 (1983)), it is purely speculative whether those costs overreported or underreported GME costs relative to GME costs reported in the GME base year of 1984.

determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate.").

Petitioner does not contend that the Secretary lacked authority to modify the consistency rule for the benefit of hospitals, and it likewise does not contend that the consistency rule prevents the Secretary from rectifying past errors in cost classifications. See *Carle Found. Hospital* v. *Shalala*, 57 F.3d 597, 601 (7th Cir. 1995) (requirement of consistent treatment of costs prevents abuses by Medicare providers and does not restrain the Secretary from "reclassification * * * to achieve the legally mandatory treatment" of costs); *Good Samaritan Hospital* v. *Shalala*, 873 F. Supp. at 1089 (holding that the Secretary "could reasonably conclude that the consistency rule did not preclude the reclassification * * * of erroneously classified GME costs for base years falling within the ambit of [Section] 413.86"). In any event, because the purpose and effect of the Secretary's actions is to *maintain* consistency in the treatment of costs, the Secretary's conduct clearly was reasonable. See *Samaritan Health Sys.*, No. Civ. 95-1032, slip. op. 18.

II. THE REAUDIT REGULATION IS NOT AN INVALID RETROACTIVE RULE

Petitioner argues (Br. 46-50) that the GME reaudit regulation is an invalid retroactive rule under this Court's decisions in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988), and *Landgraf* v. *USI Film Products*, 511 U.S. 244 (1994). The intermediary's reaudit of the base year, however, does not introduce any element of retroactivity into the implementation of the GME Amendment. It is therefore not surprising that every court of appeals

to have considered petitioner's contention has correctly rejected it. Pet. App. 3a (*St. Paul-Ramsey*), 25a-26a (*Toledo*), 52a-54a (*Tulane*).

Congress expressly provided the Secretary with authority to issue rules having a retroactive effect, because it made the GME Amendment (which was enacted on April 7, 1986) applicable to cost-reporting periods beginning on or after July 1, 1985. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, Tit. IX, § 9202(b), 100 Stat. 175. Thus, the GME Amendment retroactively changed the rules for reimbursement of GME services that had already been rendered prior to the Amendment's effective date. Indeed, petitioner concedes (Br. 47), as it must, that "there is some retroactivity inherent" in the GME Amendment.

The Secretary's reaudit regulation does not have that sort of retroactive effect on the reimbursement made for GME services actually rendered in the base year. It permits a reexamination of 1984 GME costs *solely* for the purpose of calculating reimbursement for cost-reporting periods beginning on or after July 1, 1985, and its effect on reimbursements in those subsequent years is subject to the limitation on reopening contained in the Secretary's own reopening regulation, 42 C.F.R. 405.1885(a). Accordingly, as the D.C. Circuit explained in *Tulane*, the reaudit rule "is not an exercise in retroactive rulemaking" because the reaudit "carries no impact for actual 1984 reimbursements and will be used only to calculate future reimbursements." Pet. App. 52a. "Rather than altering 1984 reimbursements, HHS's regulations simply permit the Secretary to use reaudited versions of those past figures for the purpose of determining reimbursements in succeeding years." *Id.* at 54a.

The reaudit rule does not affect or impair a hospital's existing right to retain reimbursements received prior to July 1, 1985, because the reaudit figures are not used to recoup reimbursement for any cost-reporting year for which the three-year reopening period has elapsed. 54 Fed. Reg. 40,302 (1989); 42 C.F.R. 413.86(e)(1)(iii). Thus, the reaudit rule does not "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Landgraf*, 511 U.S. at 280.

This Court repeatedly has made clear that "a statute 'is not made retroactive merely because it draws upon antecedent facts for its operation.'" *Landgraf*, 511 U.S. at 270 n.24 (quoting *Cox* v. *Hart*, 260 U.S. 427, 435 (1922)); see also *Reynolds* v. *United States*, 292 U.S. 443, 449 (1934) ("A statute is not rendered retroactive merely because the facts * * * upon which its subsequent action depends * * * are drawn from a time antecedent to the enactment."). Here, the determination of amounts due providers for GME expenses incurred on or after July 1, 1985, depends on antecedent facts (the reasonable amount, as currently determined, of GME expenses for the 1984 base period). Because a reaudit of the base period involves only a determination of past facts that operates with prospective effect, it does not effect a retroactive change. See *Tulane*, Pet. App. 54a ("within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive," because "the regulations contemplate only the use of past information for subsequent decisionmaking").[24]

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[24] Contrary to petitioner's contention (Br. 49-50), the reaudit rule is fully consistent with this Court's observation in

Petitioner also asserts that the reaudit rule violates the principle that "the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place." Br. 48 (quoting *Landgraf*, 511 U.S. at 265). In promulgating the reaudit rule, however, the Secretary made clear that the reaudits would apply only those cost principles that were in effect at the time the costs were incurred. See 54 Fed. Reg. 40,301 (1989) ("[N]o new reimbursement principles will be applied * * *. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied."); see also *Toledo*, Pet. App. 25a-26a ("While the reaudit regulation does require a determination based upon events occurring in the base year, it does not change the standards under which the base year costs are to be determined."). The reaudit rule therefore does not retroactively apply new legal standards to petitioner's past conduct.[25]

Hughes Aircraft Co. v. *United States*, 117 S. Ct. 1871, 1878 (1997), that "extending a statute of limitations after the preexisting period of limitations has expired impermissibly revives a moribund cause of action." As the Court in that case explained, such an extension would increase a party's liability by "creat[ing] a new cause of action." *Ibid.* Unlike a law that retroactively extends a limitations period, however, the reaudit rule does not create a new claim against hospitals or increase their liability with respect to prior conduct. Thus, petitioner is wrong in contending (Br. 47) that the reaudit rule "imposes a significant *new* burden on 1984 conduct."

[25] In contrast, the Secretary's regulation at issue in *Bowen* attempted to provide for recoupment under a new substantive standard of sums previously paid to hospitals. 488 U.S. at 207.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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